CCSHCN-E107
Rev. 11/09

Infant Audiological Assessment & Diagnostic Center Program Modification

Date: _____

Agency Information

Agency Name:

Authorized Contact: Title:

E-mail Address: Authorized Contact Phone:

Agency Address On File:

City: State: Zip:

Mailing Address On File (if different):

Agency Phone: Toll-free: Fax:

Updates

Please check all that apply.

☐ **Employment of Audiologist(s)** – attach copies of professional licenses

KY License #:
KY License #:
KY License #:
KY License #:
KY License #:
KY License #:

☐ **Termination of Employment of Audiologist(s)**

Date Employment Ended:
Date Employment Ended:
Date Employment Ended:

☐ **Move of Agency** (Date of Move: _____)

New Address:
New Address Line 2:
City, State, ZIP:
Phone:

☐ **Addition of Location(s)**

New Address:
New Address Line 2:
City, State, ZIP:
Phone:

New Address:
New Address Line 2:
City, State, ZIP:
Phone:

☐ **Significant Modification to Policy or Procedure – Audiological Evaluations**
(Please attach documentation of modification)

Signature

On behalf of the agency, I certify that my answers are true and complete to the best of my knowledge

_____ _____
Authorized Contact Signature Date

When complete, please submit this form, with all attachments to:

CCSHCN, attn: Early Hearing Detection & Intervention
310 Whittington Parkway, Louisville KY 40222